

Appendix 3b: Patient medication questionnaire – Gabapentin or pregabalin

To be completed before your medication review appointment. Your answers will help your healthcare provider understand how this medicine is affecting you – what’s helping, what’s not, and what changes you might want to consider.

1. Your medicines											
Which medicine are you taking?	<input type="checkbox"/> Gabapentin <input type="checkbox"/> Pregabalin <input type="checkbox"/> Not sure										
How long have you been taking it?											
Why was it prescribed?	<input type="checkbox"/> Nerve pain <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Back pain <input type="checkbox"/> Other: _____										
2. How well is it working?											
Please rate each area on a scale from 0 (not helping at all) to 10 (helping a lot):											
	0	1	2	3	4	5	6	7	8	9	10
Pain relief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily activities (e.g. moving, self-care, work)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep/ mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Side effects											
Have you noticed any of these? (tick all that apply)	<input type="checkbox"/> Breathing difficulties <input type="checkbox"/> Feeling sleepy <input type="checkbox"/> Dizziness <input type="checkbox"/> Tiredness/low energy <input type="checkbox"/> Problems with memory or concentration <input type="checkbox"/> Poor balance or falls <input type="checkbox"/> Weight gain or increased appetite <input type="checkbox"/> Changes in mood (e.g. low mood, irritability)										
	<input type="checkbox"/> Swollen ankles, feet or hands <input type="checkbox"/> Changes in bowel habits (e.g. constipation or diarrhoea) <input type="checkbox"/> Dry mouth <input type="checkbox"/> Headaches <input type="checkbox"/> Blurred vision <input type="checkbox"/> Other: _____										
Have side effects affected your daily life or wellbeing?	<input type="checkbox"/> Yes (explain: _____) <input type="checkbox"/> No										

4. Withdrawal or missed doses

<p>If you miss or reduce a dose, do you notice: (tick all that apply)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Pain getting worse <input type="checkbox"/> Sweating <input type="checkbox"/> Feeling unwell (flu-like) <input type="checkbox"/> Feeling sick <input type="checkbox"/> Shaking or trembling <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Feeling anxious, restless or low <input type="checkbox"/> Fast or pounding heartbeat <input type="checkbox"/> Headache <input type="checkbox"/> Other: _____
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5. Your experience and goals

<p>Biggest positives of this medicine:</p>	
<p>Biggest downsides or concerns:</p>	
<p>What matters most to you right now?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Improve daily life and function <input type="checkbox"/> Reduce side effects <input type="checkbox"/> Reduce or stop the medicine <input type="checkbox"/> Try something else <input type="checkbox"/> Stay on this medicine <input type="checkbox"/> Support with mood or mental wellbeing <input type="checkbox"/> Other _____
<p>Would you like to discuss any of these?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Exercise (at your own pace) <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Doing activities in small amounts <input type="checkbox"/> Pain education programmes <input type="checkbox"/> Sleep/lifestyle support <p>Wellbeing / Self-help Resources:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Live Well with Pain <input type="checkbox"/> Pain Concern information <input type="checkbox"/> <input type="checkbox"/> Pain Toolkit <input type="checkbox"/> EPP Cymru <input type="checkbox"/> Other: _____
<p>Anything else you'd like to share:</p>	